Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Surgicare

Respondent Name
American Home Assurance Co

MFDR Tracking Number
M4-14-0199-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…our claim was short-paid due to incorrect allowed amounts for each code billed."

Amount in Dispute: $628.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2013	25115, 26160, 26145	$628.14	$628.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the guidelines for reimbursement for services provided in ambulatory surgical centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 59 – Processed based on multiple or concurrent procedure rules
   - 16 – Claim/service lacks information which is needed for adjudication

Issues

1. Did the requestor request support calculations of fees?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. Per 28 Texas Administrative Code §134.402(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR (date of service), or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Amount Billed	Rule 134.402 (f) MAR (Geographically adjusted Medicare ASC reimbursement)
April 17, 2013	25115	$4,173.00	ASC reimbursement divided by 2 multiplied by CBSA city wage index, sum of these two, multiplied by 235% or 872.73÷2=436.37 x 0.9844= 429.56 436.37+429.56 = 865.93 x 235% = 2,034.94
April 17, 2013	26160	$1,707.50	665.18 ÷ 50% (Medicare Multiple Procedure Discount applies) = 332.59÷2=166.30 x 0.9844= 163.71 166.30 +163.71= 330.01 x 235% = 775.52
April 17, 2013	26145	$1,677.50	665.18 ÷ 50% (Medicare Multiple Procedure Discount applies) = 332.59÷2= 166.30 x 0.9844 = 282.16 166.30 +163.71= 330.01 x 235% = 775.52
	TOTAL	$7,558.00	3,585.98

3. The total maximum allowable reimbursement for the services in dispute if $3,585.98. The carrier previously paid $2,956.16. The requestor is seeking $628.14. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $628.14.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $628.14 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.